A summary of the rules pertaining to the Department of Defense's Continued Health Care Benefit Program (CHCBP) coverage.

What is CHCBP?

- Implementation of the CHCBP was directed by Congress in section 4408 of the National Defense Authorization Act for Fiscal Year 1993. This law directed the implementation of a program of temporary continued health benefits coverage comparable to the benefits provided for former civilian employees of the Federal government. The CHCBP is a premium based temporary health care coverage program that will be available to qualified beneficiaries. Medical benefits under this program will mirror the benefits offered via the basic CHAMPUS program. The CHCBP is not part of the CHAMPUS program; however, it functions under most of the rules and procedures of CHAMPUS.

How long does CHCBP coverage last?

- For any member discharged or released from active duty or full-time National Guard duty, whether voluntarily or involuntarily, coverage under the CHCBP is limited to eighteen (18) months.
- For an unmarried dependent child of a member or former member, coverage under the CHCBP is limited to thrity-six (36) months.

Who is eligible?

A person who:

- Is discharged or released from active duty, whether voluntarily or involuntarily, under other than adverse conditions, and was entitled to medical and dental care under a military health care plan: and
- Is not eligible for any benefits under CHAMPUS OR TAMP

A person who

- Ceases to meet requirements for being considered an unmarried dependent child of a member or former member of the Uniformed Services;
- On the day before ceasing to meet those requirements, was covered under CHAMPUS or TAMP as a dependent of the member or former member; and
- Would not otherwise be eligible for any benefits under CHAMPUS.

A person who:

- Is an unremarried former spouse of a member or former member of the Uniformed Services;
- On the day before the final decree of divorce, dissolution, or annulment was covered under a health benefits plan under CHAMPUS or TAMP as a dependent of the member or former member; and
- Is not eligible for CHAMPUS as a former spouse of a member or former member.

Enrollment

- In order to enroll in the CHCBP, an eligible individual must request enrollment via an application or letter to:

  CHCBP Administrator
  P.O. Box 1608
  Rockville, MD 20849-1608
- Although beneficiaries have sixty (60) days to enroll in the CHCBP, the period of coverage must begin on the day after entitlement to a military health care plan ends (including transitional health care under TAMP).
- The application must also include payment for the premium for the first quarter (three months) coverage under the CHCBP.
- Applications must be accompanied by proof of eligibility such as DD 214, Defense Enrollment eligibility Reporting System (DEERS) or any other official statement of service, and / or proof of dependency status.

What does CHCBP cost?

- Premium rates are established by the assistant secretary of Defense (Health Affairs) for two rate groups, individual and family. The rates are based on Federal Employee Health Benefit Program employee and agency contributions which would be required for a comparable health benefits plan, plus an administrative fee. The premium rates may be updated annually and will be published when updated. The rates are also available from CHCBP Administrator.
- Members discharged or released from active duty or full-time National Guard duty must select their rate group at the time they enroll, either individual or family. After enrollment, beneficiaries may change from family to individual at any time by notifying CHCBP Administrator in writing. Changes from individual to family may not be made.
- Premiums are to be paid quarterly by check or money order. Payment must be received no later than thirty (30) days after the start of the quarter.

Additional Information

- Write or call:
  CHCBP Administrator
  P.O. Box 1608
  Rockville, MD 20849-1608
  1-800-809-6119

CHCBP Form #7537 (EF)
Rev. 04, 9/14/94

Continued Health Care Benefit Program

For The Office of the Assistant Secretary of Defense (Health Affairs)

1. Applicant's name _____
(Title) (First) (Middle) (Last) (Area Code and Phone No.)

2. Residence Address _____
(No. and Street and Apt. No.) (City and State) (Zip code)

3. Address where policy will be delivered _____
(No. and Street and Apt. No.) (City and State) (Zip code)

4. Social Security No. _____

5. a. If service member, date of entry on active duty _____

b. If eligibility is created by termination of military benefits, check reason and show date such benefits end:

- ❑ Separation from active duty. Date MFT/CHAMPUS benefits end _____.
- ❑ Divorce. Date CHAMPUS benefits end _____.
- ❑ No longer a dependent child. Date benefits end _____.
- ❑ Unremarried former spouse. Date benefits end _____.
- ❑ Unremarried former spouse drawing annuity / retainer pay. Date benefits end _____.

6. Service sponsor through whom you qualify _____
(Name) (Social Security No.)

7. Complete the following for each person (including yourself) to be covered.

Name	Social Security Number	Age	Date of Birth (Mo/Day/Yr)	Sex (M/F)	Full-time Student (Yes or No)
Applicant:					
Spouse:					
Child:*					
Child:					
Child:					

*Children age 21 (23 if a full-time student) losing military coverage must apply separately for their own certificate at adult premiums. If more than three children, use separate sheet of paper.

8. Individual Three-Month Premium is $410.00 Family Three-month Premium is $891.00

Total Three-month Premium Enclosed: $ _____ Premium paid is for: ❍ Individual coverage ❍ Family coverage.

9. Do you or any covered dependents currently have other insurance? ❍ Yes ❍ No _____
(Name of Carrier)

Validation of Eligibility

Name and Address of Separation Center or Appropriate Authority_____

Validation by _____ Phone No. _____

APPLICATIONS MUST BE ACCOMPANIED BY PROOF OF ELIGIBILITY SUCH AS DD 214, DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS) OR ANY OTHER OFFICIAL STATEMENT OF SERVICE, AND/OR PROOF OF DEPENDENCY STATUS.

Mail this application along with a check or Money Order payable to **United States Treasury** to:

CHCBP Administrator
P.O. Box 1608
Rockville, MD 20849-1608

CHCBP Toll Free Number:
1-800-809-6119

Premium payment must accompany application. Paid by: Check Money Order (make check/M.O. payable to **United States Treasury)**

Dated at _____, on _____, 19 ___, _____
(City, State) (Month/Day) (Yr) (Signature of Applicant)

Have you: Checked all appropriate boxes and signed the application? Included premium payment? Included proof of eligibility?

CHCBP Form #7524
Rev. 04, 09/12/94